

FILED DEC 31 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **45464**

BIRTH NO. _____		REG. DIST. NO. <u>306</u>		PRIMARY REG. DIST. NO. <u>4453</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Peters</u>				c. CITY OR TOWN <u>St. Peters.</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>none</u>				e. STREET ADDRESS (If rural, give location) <u>0700</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>Anton</u>		b. (Middle) <u>C.</u>		c. (Last) <u>Loeffler</u>	
4. DATE OF DEATH		(Month) <u>Dec.</u>		(Day) <u>23,</u>		(Year) <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>March 25, 1890</u>		9. AGE (In years last birthday) <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Highway Maint.</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Peters, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Joseph Loeffler</u>		13b. MOTHER'S MAIDEN NAME <u>Katherine Schneider</u>		14. NAME OF HUSBAND OR WIFE <u>Marie Loeffler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>486-14-4442</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mo. Address</u> <u>Clarence Loeffler, RRI, St. Charles</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>myocardial infarction</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>				INTERVAL BETWEEN ONSET AND DEATH <u>44 hours</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____		21d. TIME OF INJURY (Month) _____ (Day) _____ (Year) _____ (Hour) _____ (Min) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____					
22. I hereby certify that I attended the deceased from <u>Aug</u> , 19 <u>42</u> , to <u>Dec 23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 22</u> , 19 <u>57</u> , and that death occurred at <u>10 A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Joseph A. Loeffler, M.D.</u>		23b. ADDRESS <u>St. Charles, Mo.</u>				23c. DATE SIGNED <u>Dec 24, 57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Dec. 26, 1957</u>		24c. NAME OF CEMETERY OR CREMATORY <u>All Saints Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Peters, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Dec 26, 57</u>		REGISTRAR'S SIGNATURE <u>Ed K. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. Shepater</u> ADDRESS <u>St. Peters, Mo.</u>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *E. A. Keitt*

Licensed Embalmer No. *877*

P. O. Address *Of allan*

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.

If this body is not embalmed, fact should be so stated above: *At 10:00 A.M.*